PA DEPARTMENT OF HUMAN SERVICES
MAAC BRIEFING DOCUMENT
HIV/AIDS **ANTIRETROVIRALS**

Proposed Effective Date: January 1, 2020

Revisions are noted with a ~~strikethrough~~ for deletions and **bold and underline** for additions.

I. Requirements for Prior Authorization of HIV/AIDS ~~Medications~~ Antiretrovirals

A. Revisions to Prescriptions That Require Prior Authorization

Prescriptions for HIV/AIDS ~~Medications~~ **Antiretrovirals that** meet any of the following conditions must be prior authorized:

1. A non-preferred HIV/AIDS ~~Medication~~ **Antiretroviral.** See the Preferred Drug List (PDL) for the list of preferred HIV/AIDS ~~medications~~ **Antiretrovirals** at: https://papdl.com/preferred-drug-list.

2. **An HIV/AIDS Antiretroviral with a prescribed quantity that exceeds the quantity limit. The list of drugs that are subject to quantity limits, with accompanying quantity limits, is available at: http://www.dhs.pa.gov/provider/pharmacyservices/quantitylimitslist/index.htm.**

3. A ~~prescription for a~~ non-nucleoside reverse-transcriptase inhibitor (NNRTI) when there is a record of a recent paid claim for another NNRTI in the DHS Point-of-Sale On-Line Claims Adjudication System (therapeutic duplication).

4. A ~~prescription for a~~ protease inhibitor when there is a record of a recent paid claim for another protease inhibitor in the DHS Point-of-Sale On-Line Claims Adjudication System (therapeutic duplication).

B. Revisions to Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an ~~non-preferred~~ HIV/AIDS **Antiretroviral**, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. **For a non-preferred HIV/AIDS Antiretroviral, all of the following:**

   a. **One of the following**:

      i. Has a documented history of ~~therapeutic failure,~~ contraindication, intolerance, or lab test results showing resistance to the preferred HIV/AIDS ~~Medications~~ **Antiretrovirals with the same mechanism of action as the requested agent** ~~OR~~

      ii. Has a current history (within the past 90 days) of being prescribed the same non-preferred HIV/AIDS ~~Medication~~ **Antiretroviral**, ~~OR~~

   b. Is being treated for a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication,

c. **Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature;**

AND

2. For therapeutic duplication, ~~whether~~ **one of the following**:

    a. For an NNRTI, is being titrated to or tapered from another NNRTI,
    b. For a protease inhibitor, is being titrated to or tapered from another protease inhibitor, ~~**OR**~~
    c. Has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines;

~~**OR**~~ **AND**

3. **If a prescription for an HIV/AIDS Antiretroviral is in a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in the Quantity Limits Chapter.**

    NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of ~~the request for~~ a prescription for an HIV/AIDS ~~Medication~~ **Antiretroviral**. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

D. References

1. DHHS Panel on Antiretroviral Guidelines for Adults and Adolescents – A Working Group of the Office of AIDS Research Advisory Council (OARAC). Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Last Updated: October 25, 2018; Last Reviewed: October 25, 2018.
2. HHS Panel on Antiretroviral Therapy and Medical Management of Children Living with HIV. Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection. Last Updated: April 16, 2019; Last Reviewed: April 16, 2019.
3. Trogarzo Prescribing Information. Theratechnologies Inc. May 2018.